retary and Treasurer; Trustees: Drs. B. E. Stevenson, F. Stabel and R. E. Bolling. Executive Committee: Drs. S. T. White, Robt. T. Legge and L. A. Bauter.

Dr. Robert T. Legge presented a paper reporting the clinical history of many cases of typhoid fever occurring in an epidemic in McCloud in the summer and fall of 1903. This paper elicited much interest and evoked considerable discussion.

A paper by Dr. C. E. Reed, subject, "Peritonitis," was also read and discussed.

R. F. WALLACE, Secretary.

MEDICAL SOCIETIES.

Redlands Medical Society.

The first meeting of the Redlands Medical Society since the summer vacation was held on Wednesday afternoon, October 18, 1905. A large attendance was present. Drs. Woods Hutchinson and H. G. Hill, of Redlands, and Dr. I. B. Parker of Grant's Pass, Oregon, were visitors. Dr. M. Antoinette Bennette, of San Bernardino, was elected a member. An application for membership was received from Dr. Woods Hutchinson, formerly of Portland, Oregon, now a resident of Redlands. The committee appointed at the June meeting to draw up resolutions expressing the views of this society in regard to contract practice, etc., reported as follows:

"To the officers and members of the Redlands Medical Society: Your committee to whom was referred Amendments Nos. 1 and 2 adopted by the Sonoma County Medical Society would beg leave to report as follows:

"We appreciate the endeavor to maintain at a dignified figure charges for professional services, and believe contract work as it exists in certain benevolent societies and with individual families should be discountenanced. On the other hand, we think we may contract to act as railway surgeons and not merit expulsion from any medical society on account of such contract.

"Signed and submitted respectfully,

J. E. PAYTON,
T. M. BLYTHE,
Committee."

The report of the committee was duly accepted and was adopted by the society.

The paper of the day was by Dr. Gayle G. Moseley, his subject being "Prognosis in Tuberculosis." A general discussion ensued. The society adopted a motion to hold evening meetings hereafter.

* * * * *

The November meeting of the society was held at the residence of Dr. D. C. Strong on Wednesday evening, the 15th, the president, Dr. C. A. Sanborn, in the chair. Dr. Taltavall, the secretary, being absent, Dr. Moseley was appointed secretary for the evening. Those present were Drs. M. Antoinette Bennette, of San Bernardino; J. H. Evans and W. P. Burke, of Hyland: F. H. Koepke, of Mentone; and J. L. Avey, Hoell Tyler, E. A. MacDonald, C. E. Ide, F. H. Moore, D. C. Strong, S. Y. Wynne, T. C. Pounds, J. A. Shreck, G. G. Moseley, H. M. Haskell, Woods Hutchinson, W. B. Power and C. A. Sanborn, of Redlands.

The paper of the evening was presented by Dr. Wynne, his subject being "The Doctor." He reviewed the history of the doctor and his relation to the people from ancient times to the present day. He also advocated a national board of Medical examiners to be appointed by the government, and that a certificate from this board should be recognized by the examining boards of the different States. The paper was discussed at length by all the members present.

Dr. Tyler reported a case of large abscess in the sheath of the rectus muscle just above the bladder, following typhoid fever; also a case of skin-grafting for a severe burn. Dr. Power exhibited an exceptionally large prostate and two large calculi removed from a patient by the perineal route.

The matter of the contamination of the water supply was discussed, and, while it could not be said positively that our water supply was polluted in any way, it was thought best to appoint a committee to investigate the matter and report at the next meeting. The president named Drs. Power, Hutchinson and Tyler as such committee.

The thanks of the society were extended to Dr. Strong for his courtesy and entertainment.

Dr. Sanborn invited the society to hold the next regular meeting at his residence, which invitation was accepted.

G. G. MOSELEY, Secretary pro tem.

Northern District Medical Society.

On November 14, 1905, occurred the annual meeting of the California Northern District Medical Society. A large number of doctors from the northern part of the State attended. The regular session was held in Masonic Hall from three to five, during which time the following program was carried out:

Address by R. B. Knight, President of the San Joaquin County Medical Society.

Remarks by B. J. Powell, Chairman of the Committee of Arrangements.

Annual Address of the President, "Mechanical Obstruction of the Ileo-Cecal Valve," by J. D. Dameron.

"Tetanus Antitoxine," with report of a case, by D. F. Ray.

"Rupture of Abdominal Viscera," by A. M. Henderson.

"Frequency of Pterygia in the San Joaquin Valley," by B. J. Powell.

"The Terminal Stages of Cardio Vascular Disease," by E. W. Twichell.

The business session was held from seven to nine in the evening. Between the hours of five and seven the visiting doctors were taken in private carriages, carry-alls and automobiles to visit some of the prominent hospitals and points of interest in and about Stockton. They received a special welcome at the Emergency Hospital where they were shown through by Dr. Ladd, the attending surgeon. At St. Joseph's Home, the sisters and nurses in charge gave the visiting doctors a cordial reception and every part of the hospital was visited. The Stockton Athletic Club was also visited and other points of interest.

In the evening the local medical society tendered the California Northern society a banquet at Philson's Cafe.

The following toasts were happily responded to: "The California Northern District Medical Society," Dr. E. E. Stone, Napa; "Stockton," Dr. J. D. Dameron, Stockton; "State Society," Dr. J. H. Parkinson, Sacramento; "Reminiscences," Dr. A. W. Hoisholt, Stockton; "The Full Stomach," Dr. W. E. Bates, Yolo; "The Ladies," Dr. F. R. Clarke, Stockton; "Sacramento," Dr. A. M. Henderson, Sacramento; "The British Medical Society," Dr. W. W. Fitzgerald, Stockton; "Our Babies," Dr. H. W. Taggart, Stockton.

Adjournment to meet in Chico for the semi-annual meeting.

BARTON J. POWELL.

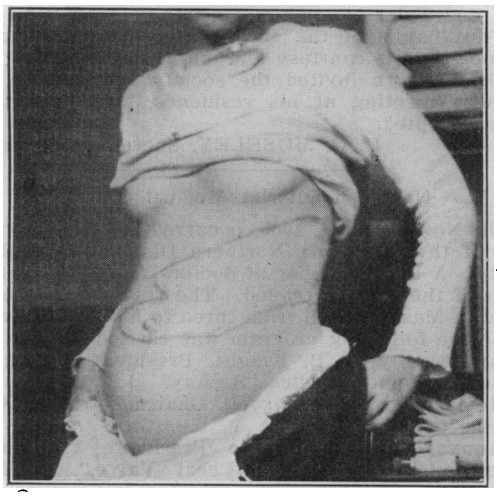
San Francisco Polyclinic Gathering.

Dr. Ryfkogel exhibited a specimen and photograph from a case of Banti's disease.

The patient, a female aged 40, height 5 ft. 3 in., weight 122 lbs.; mother had died of cirrhosis, began to vomit blood and pass blood from rectum in 1898. She had spell of cramps about this time and shortly afterward noticed a tumor in her side. She had had swelling of the feet, but showed none at the time of examination. At intervals she had had abundant ptechial hemorrhages and shortly after Dr. Ryfkogel first saw her she had an attack of these on the legs, which became almost confluent. As far

as she knew she had not had any extensive abdominal dropsy, but thorough examination showed presence of some fluid in the flanks.

On examination the heart and lungs were normal, liver was definitely smaller than normal. The spleen was greatly enlarged, extending 2 centimeters below the umbilicus and 7 centimeters to right of the median line. The notch could be distinctly felt.



The spleen was removed by Dr. Ryfkogel August 13, 1904, through a median incision. It was extensively adherent to the stomach, bowels and diaphragm and to the liver, which was markedly cirrhotic. The very severe hemorrhage resulting from these adhesions could only be controlled by packing. Unfortunately the wound became infected. The patient did well otherwise for four weeks, although in the last two weeks she showed a slight daily evening rise of temperature. One day while on the roof garden she suddenly collapsed, vomited blood and died 36 hours later.

The autopsy showed a thrombosis of the superior mesenteric vein, beginning gangrene of the small intestine and a small abscess under the diaphragm at the side of the tip of the Mickulicz drain.

On first examination the blood showed 3,590,000 red cells, 2000 white cells and 30 per cent hemoglobin. Before operation this rose to 40 per cent. The differential count showed 77 per cent neutriphiles, 9 per cent large mononuclears, 2 per cent eosinophiles, 12 lymphocytes, no myelocytes. After the operation the white cells shot up to 25,000, but subsequently dropped to 12,000. The hemoglobin after operation rose to 60 per cent and was at this point at the time of her death.

Dr. M. W. Frederick: The young woman whom I present to you to-night first came under my treatment in the month of May, this year. At that time both nares were quite blocked, and the lids of the right eye were so swollen that the eye could not be opened. A partial removal of the contents of the right naris caused the swelling in the region of the right eye to subside, and also allowed a small amount of air to pass through the right nostril. She was then taken to a hospital, with the object of removing the ethmoidal cells, and cleaning out the sphenoidal sinus, which were supposed to be the seat of the disease. Opening into the maxillary sinus, through which the operative procedures were to take place, was very easy, as with the first stroke of the mallet the buccal wall of the sinus came away in one piece, disclosing a sinus which seemed perfectly healthy. The removal of the ethmoidal cells and the entrance into the sphenoidal sinus offered no difficulty whatever, so that there was all reason to believe that the result of the operation would be satisfactory. After her return from the hospital she was treated in the office for several weeks, but the stenosis of the nostril kept increasing. What annoyed me more than anything else were the masses of brawny exudate which kept reforming, no matter how often I removed them. A searching examination gave me good grounds to suspect lues, and to begin the exhibition of potassium iodide. The effect was almost magical. The exudates disappeared and the tissues of the nose began to shrink, not alone on the operated, but also on the other side. After about two weeks a large sequester of dead bone in the septum was seen and removed. Since then there has been no further trouble, and, as you can see to-night the nose is quite free, and the opening into the right sphenoidal sinus can be seen by anterior rhinoscopy. There is no bad odor to the nose, whereas at first it was very unpleasant to come near the patient.

The reason I show this case to-night is to emphasize the fact that the nose and throat specialist must be constantly on the lookout for lues. In this case, having an unmarried female to deal with, I felt backward about asking pointed questions, and when I did make up my mind to find the truth I had to preface my questions with a profuse apology in case I were on the wrong track. But the nose and throat are such places of predilection for lues in all its stages, that one must constantly bear it in mind. In this case the patient would have been saved the annoyance of the operation had the correct diagnosis been made at the outset.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

The regular monthly meeting was held on November 19th in the rooms of the San Francisco Polyclinic the president, Dr. K. Pischel, in the chair.

The scientific program follows:

Dr. Geo. H. Powers presented a case where a rusty rivet entered the eye of patient. He considered the foreign body to be lodged in the sclera and thought that the eye need not be removed as the trouble was not involving the ciliary body. When the patient came to him there was marked chemosis, traumatic cataract with no light reflex. Patient could barely count fingers and suffered no pain. The doctor presented an admirable skiagraph showing the foreign substance in position.

Dr. Barkan said that the foreign body should be located and an attempt made to remove the same. Failing in this the eye must come out.

Dr. Card concurred in this view.

Dr. Pischel had the same suggestion.

Dr. W. F. Southard presented a case of burning of the conjunctiva and cornea with lime. The patient works in a beet sugar refinery and accidentally got some of the mixture of molasses and lime into his right eye. There was extensive inflammation of the palpebral conjunctiva, but no symblepharon. The cornea had a peculiar whitish appearance and the iris and pupil were invisible. No pain. These burns resemble those of babbitt metal and the doctor asked whether the burn extended below the epithelium, as upon this point the prognosis depended. The treatment was sterilized vaseline, to prevent adhesions, and atropine.

Dr. Southard also presented a case of microphthalmos, with a congenital cataract. The cataract is usually found in these cases and is not developed. The eye would not have useful vision even were the cataract removed.

Dr. Card suggested needling of same.

Dr. Southard thought this might be done but for cosmetic reasons only.

Dr. Powers showed a little boy who had been operated on for convergent strabismus, by the Panas method. The operation was performed here at St. Mary's Hospital by Dr. D. B. St. John Roosa of New York. Sight was nearly normal in both eyes, patient accepting under atropine a plus 0.75 sphere and getting twenty-twentieth vision. There was possibly 2 degrees of convergence at present.

Dr. Powers had read much about this operation and as Panas, a reliable authority, had performed it a number of times on the cadaver before trying it on the living he felt that his views were correct. Dr. Roosa had performed the operation a number of times in New York with almost uniform success. The procedure is based upon the assumption that in strabismus both eyes are involved and the contracted muscles are in a state of clonic spasm. Therefore they are to be stretched before severed. This is done usually under general anesthesia, both eyes being operated at the same sitting.

The eye is grasped with forceps and slowly turned out or inward, as the case may be, and held in that position for a few minutes. This stretches the offending muscle and overcomes the contraction. It is now cut at its insertion and a purse-string suture closes the conjunctiva. The same is done to

the other eye and both are bandaged. A few days later, if divergence exists, nothing is done; if convergence, the accommodation is paralyzed with atropine, and when the redness has disappeared the proper correcting lenses are prescribed.

Dr. Barkan thought that one should be loath to operate both eyes at the same sitting. He said that he would like to see how long the correction would last, and mentioned some cases where he had found it necessary at the expiration of some years to reoperate.

Dr. F. B. Eaton considered the dynamic convergence as about 5 degrees and did not admire the operation. He considers a muscle weakened by this stretching process.

Dr. W. S. Franklin referred to Prof. Schweigger's method of forcibly turning the eye outward after the muscle had been cut. The only difference between the two operations was this fact, i. e., the turning or stretching before or after the muscle was severed. Schweigger had special forceps for this purpose and he did it with the hope of having the cut end of the muscle attach itself to the eyeball further back than it ordinarily would.

Dr. Powers said that he would present the case again at the expiration of six months and thought that that would be ample time to judge the ultimate result.

Dr. R. D. Cohn presented a case of unilateral exophthalmus. The patient was a female, 19 years old, with no history bearing upon the present condition. Right eye has protruded 10 years and patient came to the clinic for another trouble. The vision was good, 6-18—6-12, no fundus changes. X-rays showed no appreciable shadow. The exophthalmus is not increasing and the patient has luxated the bulb a number of times, this latter condition disturbing her mentally. He has given potassium iodine in large doses (5.0–6.0 gm. daily) with no effect upon the protuberance. He considers this a case of benign neoplasm within the orbit.

Dr. Barkan thought this a benign tumor, saying that it might be fatty or an angioma. He felt that the doctor was justified in exploring the orbit by Krönlein's method.

Dr. Powers mentioned a case wherein he had replaced a luxated bulb, the patient being the pet dog of one of his friends. He asked whether, in this case, the sinuses of the nose had been examined.

Dr. Franklin described a case he had witnessed at Fuch's clinic where the orbital tumor proved to be a serous cyst which was opened during the course of the operation, leaving practically no trace of the walls.

Dr. A. Barkan showed a case of one-sided "Morbus Basedowii." These occur in rare instances. It had developed quickly, some tachycardia was present, but Stellwag's and Graeffe's signs were missing. No fundus changes, no bruit.

When the eye is palpated and pushed back into the orbit the patient notices that the next day she has a hemorrhage from the nose.

Dr. Franklin thought that the right eye was only relatively exophthalmic. He considered the left eye as also affected and somewhat prominent, but being so to a lesser degree than the right it gave the latter the appearance of single prominence.

Dr. E. F. Card described a case of hysterical aphonia. The patient was 12 years of age, healthy, but rather phlegmatic in all her actions. Weight 150 lbs. She recovered her voice with the usual treatment (strong faradic current) and was permanently cured.

Dr. Welty minutely described the treatment, insisting upon the fact that these patients must be made to talk at the first visit. Drs. Cohn, Southard and Franklin described similar cases.

W. SCOTT FRANKLIN, Secretary.

MEETING OF CALIFORNIA PUBLIC HEALTH ASSOCIATION, SAN FRANCISCO, OCTOBER 28, 1905.

The president addressed the members of the convention in part as follows: "This is the fifth session of the California Health Association. The object of this meeting is to promote the various methods of forwarding the public health of the State of California, and especially to discuss subjects such as have been suggested by our program.

"Sanitary science is receiving much more attention in the last decade than it has at the hands of Americans during any previous decade. It is dealing with the problem of medicine on broader lines than usual and the results are much greater, so I feel that in belonging to a convention of this kind we are engaged in the most practical medical work that the world knows at present. * * *

"It is not my intention to prolong the introductory speech. I desire to express satisfaction in seeing you here and hope that we may have a successful meeting to-day, and before we leave, lay lines for the meeting next April, when the Association will convene again in this city."

The first paper on the program was an address by Dr. W. F. Snow of the Stanford University on the subject of "Sanitation of Stanford."

In the absence of Dr. Wilbur Dr. Foster opened the discussion as follows: I have been extremely interested in the paper from the fact that it covers ground that has needed covering for a long time in this State. There have been spasmodic attempts made all through the State to do sanitary work and establish certain records, but they have not been continuous, and being isolated, with no relation to the health office, they did not reach the point which they should have reached in order to do any lasting amount of good. I can imagine, in Palo Alto, after their experience, that they will never have another epidemic of typhoid fever. They know the whole sanitary condition of the district, and in the event that one case of typhoid fever appears, or any other disease that is born like that, they could put their finger upon the cause at once and stop it at once. Now, if we could have maps like this and records like this in all districts, we could bring them all together and have a sanitary map of California. It is something I have felt the need of very much. In my office a report will come from some part of the State that there is an epidemic of typhoid fever and assistance is needed. I do what I can, but I have no records. We know, in a general way, where their water supply comes from, but we have no map, even of their pipes or their relation to the sewers. There are many things that Dr. Snow could work out that would help the State—the water supply for instance—it is one of the most important things of this State. I doubt if the health officers in one-quarter of the incorporated towns of this State know anything about the water supply. They do not know where it is brought from, they do not know how old the pipes are, or whether the reservoir from which it comes has ever been cleaned.

In the State Board we have lately started a bulletin which we want to be a State issue. We want to make it a bulletin of the health officers and make it of interest to all to keep in touch with each other. * * * We want to show what is being done for the whole State and if you have anything of interest to the State send it along and we will promise it shall be published. * * * Now, the idea of a State deputy at large is a good one. It had never occurred to me and I do not know that it is possible, but it might be done; however, every health officer of this State is a deputy. It is their duty to enforce the law. Of course, they can only do it in their own district. I will not take any more of your time, but I have been very interested in the paper and I hope it will excite more discussion.

Dr. Simpson, San Jose: In my work in Santa Clara county I have in every district a deputy, and

while I could not get from each one of these deputies a map of his district and so succinct a record, each physician who has been appointed has taken sufficient interest in this matter so that, at any time, in my office, I can get in communication with one of these gentlemen and I can learn what is the condition of that part of the county. Once a month I receive a report from these gentlemen if there is anything to report. The success of the work of the health office and of my work as health officer has depended entirely upon the voluntary assistance of Dr. Snow and Dr. Wilbur and various physicians about the county, who come and help willingly. It shows the interest medical men have in the work of their community. I feel very proud of my deputies and very proud of the work that Dr. Snow and Dr. Wilbur did at the time of the typhoid epidemic and since. This is not a model for Stanford only. It is a model for the whole United States. I want the doctors of this State, and through them, the people of the State, to know that the possibility of an epidemic at Stanford is impossible.

Dr. Williams of Palo Alto, Dr. Ragan, health officer of San Francisco, and Dr. A. R. Ward of the Hygienic Laboratory at the State University, also took part in the discussion.

After a few remarks by Dr. Regensburger, president of the State Board of Health, a recess was taken until 1:30 p. m.

Afternoon Session.

The first paper on the program of the afternoon session was by Dr. Foster, on the subject of "Contamination of Water Supplies."

In the absence of Dr. Canney the discussion was opened by Dr. Snow, who said in part: There are many things that occurred to me during the reading of the paper. Dr. Foster did not speak of any definite location, but I wish to speak of Russian river, where so many of our people go for the summer. A great many students from the university go there and regularly, at the beginning of the early summer season there will be a few cases of typhoid fever along that whole region. I think it is vastly important that pressure be brought to bear upon supervisors of different districts, when people from the city are allowed to go out there and expose themselves, as Dr. Foster has outlined, and then come home as invalids.

Dr. Simpson, Dr. Ewer of Oakland, Dr. Walker and Dr. Bogle of Santa Rosa, and also Dr. Fay of Sacramento participated in the discussion.

Dr. Fay of Sacramento, read a paper on "Undrawn Fish and Poultry." Discussion followed by Dr. A. R. Ward and Dr. W. C. Hassler.

Owing to the lateness of the hour the paper on "Control of Contagious and Infectious Diseases of Aliens Arriving in San Francisco" was omitted, but the subject was ably presented by Dr. H. S. Cumming, Past Assistant Surgeon, U. S. Public Health and Marine Hospital Service, San Francisco.

On account of the unavoidable absence of Dr. Woods Hutchinson the paper on "Quarantine in Typhoid" was omitted, but the subject was briefly discussed by Dr. Fay, Dr. W. C. Hassler of San Francisco and Dr. Von Adelung of Oakland, who said: Discussion has been indefinite by reason of not knowing what we mean by quarantine. We have notification and placarding. That is a step which we take to warn people that they are near a disease which is contagious or infectious, or both. And then we have "quarantine," which means that we draw a line around certain premises. Now, the question as to whether or not we should quarantine typhoid should be determined. If it means, shall we draw a line? why, I stand entirely opposed to such procedure. I am also not in favor of placarding the house. I think we are doing all that can be done in typhoid cases if we have them reported. The important measures are to disinfect the feces and urine, and to avoid contamination of articles. These measures cannot be furthered by quarantine. Supervision by a visiting health official, or public nurse, might aid. Especially should instruction be given regarding the details of disinfecting feces and urine, i. e., the proportion of disinfectant, the time it should stand, and finally the continuance of disinfection of urine for weeks after recovery.

During the evening the Association was entertained at dinner at the Bohemian Club by Dr. James W. Ward. The members of the San Francisco Board of Health, and the President of the State Board of Health discussed the milk problem in San Francisco.

On the following morning the members were the guests of Dr. Cummins, quarantine officer, who took the party to the quarantine station where the plant was inspected, and then for a trip about the bay.

COOPER SCIENCE CLUB.

The regular meeting of the Cooper Science Club was held November 6, 1905.

Report of a case of dysentery with megastoma entericum infection by Drs. Clark and Oliver.

Dr. Clark read the following history of the case:

Patient a male, 29 years of age, a native of New Zealand, came to the clinic complaining of pain in abdomen, diarrhea and blood in stools. F. H. negative. Previous history: ordinary diseases of childhood. Malaria, rheumatism and gonorrhoea. Chancre 5 years ago, no secondaries although patient says he occasionally has sore throat. At time he had chancre, was treated locally and internally for 2 or 3 months. Alcohol none at present, formerly used a great deal. Tobacco moderately.

P. I.—In 1896 while living in Australia patient had 3 or 4 large soft movements a day. This lasted some time but recurred spontaneously. From 1896 to 1901 patient lived in the tropics and he states present trouble commenced while in Java in 1899. At that time he had a bowel movement about every half hour; the movement was soft, small, not very slimy, sometimes yellow and sometimes white in color, no blood. Was advised to go to the mountains in Java which he did, but did not improve. Was treated at Penang by internal medication without improvement. He then went to Singapore and was treated by rectal irrigation, solutions of permanganate of potash and recovered in about 10 days. Remained well for about two years, having one or two normal passages a day. In 1902 he began again to have 2 or 3 large soft passages a day gradually getting worse over a period of 6 months until he had bowel movements every half hour. Went through the same treatment of permanganate of potash rectal irrigation and recovered but recovery did not last long, occasionally having slight attacks of diarrhea, until about six months ago when they became worse and increasing in severity until coming to clinic October 23, 1905, when he had passages every half hour, small in amount, soft, occasionally slimy and containing blood. P. E.—Fairly developed and nourished, face pale. Throat red, tonsils slightly enlarged. Cervical glands very much enlarged. Lungs and heart negative. Liver and spleen not enlarged. Dull pain on pressure over abdomen. No edema of legs. Specimen of feces was obtained and sent to Dr. Oliver for examination. They were found to contain megastoma entericum in large numbers. Of this Dr. Oliver will speak. The patient was sent to Lane Hospital, given castor oil, liquid diet and permanganate of potash 1:5000 rectal irrigations. Improvement followed this treatment.

Report of case by Dr. H. R. Oliver:

Before entering on a description of our case, a brief history of the infusoria will be in order. Donne in 1836 found in the vaginal secretions of women

an undescribed parasite. These were small bodies provided with cilia and flagella on account of which he gave them the name, trichomonas with the specific name vaginale. Vogel, Siebold and Valentin denied their parasitic nature and thought them to be altered epithelial cells. His work was, however, later confirmed by Kunstler and Henneguy in France and Blochmann in Germany whose investigations, while differing in many respects have added to our knowledge. On the whole the parasites were looked upon as of little importance. Since Donne's discovery they have been found in snails, frogs, ducks, etc. Davaine first described them in cholera in the stools and in typhoid fever, and gave them the name of cercomonas hominis. Dock found that the stools of patients with amebic dysentery. They have also been found and described by Ekecrantz and others. Lambli also found them in (as he thought) the stools of children suffering from diarrhea and called by him cercomonas. But Schunberg claims that Lambli cercomonas, 1888, were really megastoma entericum and belong to an entirely different genus. Grassi found and named them mono-cercomonas but it is thought that they were really trichomonas. Epstein made extensive observations in 26 cases of infantile diarrhea and the organism found were pronounced by Prof. Hatschek to be mono-cercomonas. Sternberg found the cercomonas in the mouth. Lenhartz in abscess of the tonsil. Kranneberg in pulmonary gangrene and pleurisy. H. Hill Hassall was the first to find them in the urine and describe them under the name of Bodo urinaris. In 1883 Kunstler of Bordeaux reported the first case in which they were found in freshly voided urine but the species to which they belonged was not exactly known. In 1893 Drs. F. Tilden and Brown presented specimens and photos before the Academy of Medicine but they were later found to be the cilia. Dock was the first to describe them in America in the vaginal secretion of pregnant women at Galveston, Texas. The first undoubted case of trichomonas in the urine was Marchand's in an old man with urinary fistula of the perineum. Dr. K. Muria of Tokio reported also a case which showed flagella and an undulating membrane.

Then Dock found them in the urine of a man in Texas. Up to this time only the trichomonas vaginale of Donne, trichomonas hominis of Davaine cercomonas were found in connection with the human being.

There being some marked difference in the specie, I think it well to describe briefly some of them. The cercomonas is a small oval or round disk body and has posteriorly a single flagella. In the young forms it might be absent. The adult may lose its flagella and protrude a pseudo podia while vacuolation occurs at the same time indicating approaching death.

The trichomonas of Donne is oval or spindle shaped .012 x .01 m.m. From the anterior pole four flagella project and an undulating membrane extends laterally to posterior pole which may be rounded or taper to a tail-like appendage as in the cercomonas. They become vacuolated as death approaches. They also have near anterior pole a row of cilia. Both species in activity motile.

The megastoma entericum, Grassi-Lambli, is pear-shaped .01 x .02 x 0.075—.05 m. m. In the anterior portion is a well marked depression which constitutes the peristome or mouth. In the bottom of this depression near its anterior arc are two round hyalin bodies which represent the nucleii. It has eight flagella in pairs and directed backward. The first pair are at the outer arcs of the peristome and the second and third pair at the posterior arc of the fourth issue from the tapering tail end of the body. Vacuoles are absent, nutrition occurs by osmosis, the parasite adhering to the epithelium of intestinal mucosa by peristome. They are not motile. Grassi first observed them in 1888 in mice, cats, dogs, rabbits and sheep. The mode of reproduction in the flagellata in general is not exactly known. Kolloker and Marchand claim to have observed longitudinal division in trichomonas vaginalis. As to sporulation nothing is known of pathological importance. Cunningham, Grassi and Schunberg thought them common parasites of the intestines. Epstein, however, by his clinical observation shows that at least some of them can produce diarrhea in man. Perroncito claims that a specie of intestinal parasites cause a fatal disease in guinea pigs. Dock does not give a positive statement as to his views as to their pathogenic action.

In 1895 H. Salmon of Frankfurt reported the first authentic case of infection in man with megastoma entericum, though he states they were the same as the cercomonas of Lambli which were according to Schunberg, placed in the wrong genus by Lambli. He reports the case of a young man working in a mill who suffered from diarrhea the cause of which was the megastoma entericum, no other infusoria being present. This man's sister-in-law also had the disease, and so did the other men working in the mill. The infection was attributed to their drinking the unfiltered and unboiled water from the river Elbe.

Salmon describes the diarrhea as watery and mushy stools with some mucus and at times blood, especially after calomel. He states that after five months' treatment they were still found in the stools which were still mushy in character, although the man had returned to work. He describes the parasite as above. He attempted cultivation and animal experiments and they were both negative.

G. Hoppe-Seyler in *Modern Medicine* says we should not disregard sporozoa and infusoria for they often give rise to very stubborn intestinal catarrh which in part shows a similar picture to dysentery and amebic enteritis. In their action they are probably assisted by bacteria and we should not go so far as was done in the case of the ameba to look upon them as comparatively harmless, accidental parasites that appear in intestinal catarrh.

The infusoria diarrhea is more frequent in man than sporozoa and are due to the flagellata megastoma entericum, cercomonas and trichomonas. These parasites like the cercomonas and trichomonas and megastoma entericum rest on the epithelium or vegetate freely in the intestinal contents. They irritate the mucous membrane principally mechanically giving rise to marked peristalsis. They enter the alimentary tract through food contaminated by rats, etc., only the encysted forms pass the stomach, the gastric juice being fatal to the non-encysted forms. The encysted forms develop and give rise to large accumulations. The stools caused by them are frequent, ten to fifteen daily and are most frequent during the day and not at night. They consist of a watery or mushy mass with some yellowish colored mucus. This diarrhea weakens the patient and they finally suffer from mal-nutrition. Especially so if they are present in cases of carcinoma of gastro-intestinal tract, or in cases of tuberculosis pulmonaris. In these cases they may cause a profuse diarrhea which is checked immediately when they are removed. In the literature as far as I searched I found no mention of the occurrence of the megastoma entericum in America and the case of Salmon was the only one that can be laid to the megastoma entericum as the cause of the dysentery.

In our case as the clinical history shows, he has as high as 10 stools. Sometimes with blood and mucus and often without. In his stools I have not found any other parasites except the megastoma entericum. I found no ameba, although as Musgrave has shown us there may be and show no dysenteric symptoms, and we may have some abscesses of the liver without dysentery. Some of his stools are quite bloody especially after a purge and contain a good quantity of mucus. Esinophiles are present in

the stools in large numbers. The megastoma were of all forms, the flagellates, encysted and young. They stain beautifully with Wright's, the body strong dark blue, the peristome light blue, the nuclei bright red and the flagella reddish blue. In some, especially the larger one, I thought I could see the splitting of the chromatin of the nuclei on each side. Then these fine granules extending toward the tail on either side, the center of the organisms becoming quite dark blue and the outer sides lighter. These little granules collected in small groups and finally little spots like the presigmentation bodies in malarial hematozoon.

I can not and do not make this as a final statement as my time and observations were very limited. But they reminded me much of Craig's description of the same process in the ameba dysenteria.

On November 18th an examination of the rectum as high as the sigmoid flecture was made by Dr. Rigdon with aid of a proctoscope and light carrier. This examination showed absolutely no lesions of any nature although the mucous membrane in places looked very hyperemic and in places a little blood escaped. The man's present condition is much the same as two weeks ago. We shall try treatment again and then rest as in this time and record the increase in symptoms and number of megastoma.

DISCUSSION.

Dr. Blumer: I have seen one or two cases of this infection in Baltimore and we took a view then that is now generally accepted that the parasite is quite a common one in the intestine and is not that cause of the intestinal symptoms. I do not feel quite justified in taking that view now, especially when we consider that changes have taken place in our ideas in connection with other parasites that were supposed to be harmless. The Balintidium coli has been shown by Strong almost certainly to produce intestinal lesions. They could be found deep in the mucous membrane of the intestines. It seems to me that it will be necessary to have autopsies on some of these cases to decide whether the parasite is directly concerned with the histological lesions. The zoologists describe the parasite as simply becoming adherent to the epithelial cells. That is not a reason why they should not produce a lesion. Mechanical irritation might be sufficient. One should be very careful to exclude all other causes of dysentery in a case like this. It is quite possible too that this parasite may aggravate a dysentery which has been started by something else. I do not see how the matter can be cleared up until we have autopsies on some of the cases.

Those encysted forms that Dr. Oliver describes are pictured in Braun's work on Animal Parasites. There is a statement made that Schaudin has described a complicated form of division in the parasite.

Dr. Gunn, discussing the paper read by Dr. Oliver: I agree with what Dr. Blumer has said. I think, as far as we know, the megastoma entericum, or the lamblia duodenalis as classified by Stiles, is not pathogenic. Various flagellate infusoria, some of them exceedingly common, are observed in the intestinal tract, usually when there is present an inflammatory condition. But that they are capable of producing any lesions there is no proof and there is much to show that they are not pathogenic, such as animal experimentation, etc. The parasite described by Dr. Oliver has been found in the stomach in six or seven cases according to Nichol.

Dr. Schmoll reporting two cases of abdominal aneurysm:

The first case which I wanted to present this evening was a case of the aneurysm of the abdominal aorta. The man is 73 years of age. Noticed about 7 years ago that a pulsating tumor was growing in his abdomen causing him a great deal of pain. This tumor kept on growing for about 2 or 3 years after which time it ceased to increase in volume. About 6 months ago a physician made an exploratory laparotomy and finding an aneurysm he closed up without any further surgical interference. If you examine the patient you will find a tumor about the size of a child's head in the umbilical region. This tumor reaches below to about the promintorium where you can feel the pulsating aorta branching into the two iliac arteries. Above one can go in between the upper part of the tumor and costal margin. The tumor is quite hard and pulsating. Its nature is proven by the fact that it pulsates not only in saggital direction but also expands laterally. The lateral expansion is very little compared to the antero pulsation proving that there is a large amount of pulsating within the aneurysm, a fact which explains the stationary character of the tumor. Besides the double sciatica caused by the aneurysm the patient complains of pain in his chest. At first I thought the pain radiated from the abdominal aneurysm but lately he has shown new symptoms which makes me think that he has also an aneurysm of the descending aorta. Within the last 3 weeks he complains that the food sticks at a height corresponding about to the 4th dorsal vertebrae, that he can only swallow after some efforts. On examination the patient shows a tenderness over the 4th, 5th and 6th dorsal vertebrae on percussion. I thought that I could sometimes see pulsations there but am not sure. On auscultation there is nothing to be heard but on percussion there is a distinct dullness. The difficulty in swallowing, tenderness of the spine, intercostal neuralgia of frontal region, seemed to me to be very suspicious of the presence of aneurysm of the descending aorta.

The second case is a case of aneurysm of the ascending aorta. The man is 53 years old and has been complaining for the last 6 years of asthmatic attacks. When I first looked at the patient I was impressed by the fact that his right jugular vein was full and did not empty on deep inspiration. It was not pulsating. This can only be explained by the intra-thoracic tumor pressing upon the vena cava superior which in most of the cases is an aneurysm. I therefore looked for a normal pulsation of the chest wall and soon detected a pulsation at the third intercostal space about 4 c. m. to the right of the right sternal border. One could feel a very marked diastolic shock extending as far as the pulsation. The combination of the pulse in the normal pulse with that marked diastolic shock and booming low pitched second aortic as we hear over this chest assures the diagnosis of aneurysm. A tumor to which pulsation would be only communicated and not present diastolic shock and would not give this low pitched characteristic second aortic sound. The diagnosis was confirmed by an X-ray which showed the aneurysm on the descending aorta.

It happened that a few days after this case I saw a second case of aneurysm of the ascending arch of the aorta which was even smaller than the one in this case. The symptoms presented were a general diffuse pulsation of the whole chest wall. Very marked tug of the trachea and a general pulsation and the whole head pulsating synchronous with the radial pulse. There was a marked difference between the two radial pulses, the left being much smaller than the right and the characteristic low pitched second aortic. The X-ray of this case showed also an aneurysm of the ascending arch and a second aneurysm of the descending arch which clinically did not cause any symptoms.

DISCUSSION.

Dr. Cheney: One of the most interesting points with these cases is the frequency of aneurysm in San Francisco. Whether it is true that aneurysm is seen more often than in the East I would like to know from those who have had experience there.

Dr. Blumer: As far as New York is concerned, I will say that aneurysm is more frequent here than

in Central New York. I do not think, however, that it is more frequent here than in Baltimore where I saw a great many cases, especially among the colored people. I suppose that is due to the fact that such a large proportion of them have had syphilis at one time or another, perhaps also because Baltimore is a seaport and so many sailors have the same disease.

Dr. Lehmann explained the features of the demonstrated diapositives which both show the aneurysm of the ascending aorta very much smaller than it really is; in both cases it extends more in frontal direction than in sagittal, as shown by the screen examination which was made in all directions. Illuminating the chest not only in dorso-ventral and ventre-dorsal direction, but from one side to the other. The pressure upon the vena cava in the first case is demonstrated by the marked shadow, which is denser and larger than usually found.

Dr. Schmoll, closing discussion on his case: The frequency of aneurysm in this country is certainly very much greater than the occurrence in Europe. I have seen in this short time that I am in America, more cases than I have seen in Europe. I think there is no great difference between the occurrence of aneurysm here and Baltimore and I think in both cities the frequency of the occurrence is about the same. Regarding the treatment of these cases I usually give potassium iodid in considerable doses and gelatine in injections as advocated by Lancereaux in Paris, who had the kindness to show me about 10 to 15 cases treated by this method. I was very much impressed by the clotting which occurred in aneurysm which had perforated the chest wall. The danger of gelatine treatment is that tetanus occurs quite frequently if the gelatine is not properly sterilized. I believe that Merk puts a gelatine on the market which is absolutely sterile and can be injected without trouble. I saw 2 or 3 cases of disappearance of pulsation on the chest wall and an aneurysm which had been rapidly increased before, became stationary while the pain disappeared entirely. For the pain in aneurysm I often advocate veni section which often lessens the pain to quite a considerable degree. It often helps one to hold back with morphine.

PUBLICATION.

The Principles and Practice of Medicine.—By WILLIAM OSLER, M. D. Designed for the use of practitioners and students of medicine. D. Appleton & Co., New York.

It is a pleasure to read for review a book which one can cordially recommend. Such a work is the new edition of Osler's Practice of Medicine. It is written in short terse sentences and contains in a comparatively small bulk a wealth of historical, pathological, and clinical detail. Further, when descriptions of rare conditions are necessarily brief, the most valuable reference is repeatedly given. It has been brought well up to date and contains an account of Para-typhoid fever and the newer tropical diseases. Splenic enlargement is dealt with from the most recent standpoint. Chronic polycythemia with cyanosis and enlarged spleen is separately described, and looked upon as a clinical entity. Joint diseases are satisfactorily classified as far as our present knowledge will allow. Gaskell's Engleman's, Mackenzie's and Wencheloch's studies have been incorporated under Cardiac Arrhythemia, and this and allied subjects made very interesting. In the section on nervous diseases Sherrington's and Grienbaum's work on the higher apes is figured in the representation of the cortical localization, and the schematic diagrams of the segmental skin fields impress one with their accuracy. The sections devoted to treatment are extremely brief and perhaps reflect the therapeutic pessimism of the distinguished author.

COMMUNICATIONS.

Extravagant Claims for Hyoscine in the Treatment of Drug Addictions.

To the Editor of the STATE JOURNAL: Quite a number of articles have appeared in medical literature during the last few years advocating the use of hyoscine in the treatment of the morphine and other drug addictions. Some of these have advised its use in such large and frequently repeated doses as to make one familiar with the effects of this drug shudder to think of the distressing condition the patient must be brought into by such excessive use of so powerful an agent.

Some of these writers have made the most extravagant claims for this remedy, some claiming it to be an antidote for morphine, others that its use in combination with morphine prevents the formation of an addiction, others that it is a specific cure for the morphine addiction, and that by its use the worst cases may be cured within a few days' time.

An article appeared in the July number of your JOURNAL by Dr. Bering, of Tulare, that may be cited as an example. He gives the clinical notes of four cases, the third and fourth of which are as follows:

Case 3. Morphine habitue, using 20 gr. morphine and 20 gr. cocain daily for a period of years, was given 65 one-hundredth grain doses of hyoscine during a period of two and a half days. He was discharged cured, having no desire for either drug. Pulse remained good during treatment.

Case 4. Patient using a large quantity of morphine and cocain daily, was treated for three days and discharged cured.

When one reads such statements as these in first-class medical journals it makes him wonder whether the days of the miraculous cure of disease have really returned. In the writer's experience the cure of the morphine addiction in a few days' time is like "Learning German in ten lessons." Patients who are given such a course of treatment and discharged *cured* at the end of a few days' time find that they have about as much to contend with after their *cure* as before it, just as the would-be German scholar finds that after his ten lessons he has very much more to learn than he thought he had at the beginning. It is evident that the word "cure," as used by some of these gentlemen, does not mean what it is ordinarily understood to mean. There is much more involved in the cure of a case of morphinism than can be done in a few days' time with any course of treatment, however perfect it may be. In addition to the drug intoxication from which the patient is suffering, the system is surcharged with poisons, both of excrementitious and autotoxic origin. The functional activity of all the excretory, secretory and digestive organs are impaired. The blood changes are marked, the red corpuscles greatly diminished, the white correspondingly increased, patient profoundly anemic, muscles flabby and relaxed, nervous system deranged to a marked degree, mental activity impaired. In fact, the patient is greatly below par in every respect.

We are free to confess that we are old-fashioned enough to believe that in the treatment of this or any other disease it is still necessary to conform to well-established physiological laws, rather than depend upon some miraculous agency to transform our patient from disease to health; therefore, we do not believe that these markedly deranged conditions can be corrected in a few days' time to such a degree as to justify the patient's being discharged as cured.

The administration of sixty-five 1-100 gr. doses of hyoscine in two and one-half days—a little over 1-100 gr. every hour—is excessive medication, and would be dangerous in many cases. I do not wish to be understood as condemning the use of hyoscine in the treatment of these addictions, because it is a remedy of great value, but it has its limitations as well as its uses. It does not cure the morphine addiction, as is